

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010757</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/02/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>STERLING HOUSE OF VALPARAISO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2601 VALPARAISO STREET</b> <b>VALPARAISO, IN 46383</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00089369.</p> <p>Complaint IN00089369- Substantiated, no deficiencies related to the allegations are cited.</p> <p>Survey dates: May 1 and 2, 2011</p> <p>Facility number: 010757 Provider number: 010757 AIM number: N/A</p> <p>Survey team: Janelyn Kulik, RN</p> <p>Census bed type: Residential: 61 Total: 61</p> <p>Census payor type: Other: 61 Total: 61</p> <p>Sample: 4</p> <p>Sterling House of Valparaiso was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00089369.</p> <p>Quality review completed on May 4, 2011 by Bev Faulkner, RN</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1